

FIG. 3

User rlangdon									
File Edit View Setup									
My Patients									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
7	63y	F	car drove off cliff	Grace	11:26	04/12/01	17 MVA	langdon	
12	18m	M	bean in nose	Ricky	15:44	04/12/01	28 Nose	langdon	
Patients Waiting									
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
			NEW COMPLAINT	NEW PATIENT					
49y	F		horse stepped on foot	Ethyl	16:37	04/12/01			
118y	F		headache	Mary	16:26	04/12/01			
56y	M		car crash	Ernie	16:18	04/12/01			
29y	M		abdominal pain	Jack	15:26	04/12/01			
37y	M		chest pain	Desi	15:04	04/12/01			

3/36

FIG. 4

T-Chart		User rlangdon									
Grace		File Edit View Setup									
My Home		My Patients									
Annotations		Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
L S		7	63y	F	car drove off cliff	Grace	11:26	04/12/01	17 MVA	langdon	
Notes		12	18m	M	bean in nose	Ricky	15:44	04/12/01	28 Nose	langdon	
Clinical											
History											
Exam											
Course											
Dx/DI											
Viewing											
Report											
Discharge											
Prescription											
Excuse											
Printing											
Clinical											
Discharge											
Closure											

Patients Waiting										
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician			
	49y	F	NEW COMPLAINT	NEW PATIENT	16:37	04/12/01				
	118y	F	horse stepped on foot	Ethyl	16:26	04/12/01				
	56y	M	headache	Mary	16:18	04/12/01				
	37y	M	car crash	Ernie	15:04	04/12/01				
	29y	M	chest pain	Desi	04/12/01	3 2				
			abdominal pain	Jack						

4/36

FIG. 5

T-Chart		User rlangdon									
Jack	File Edit View Setup [Icons]										
My Home	My Patients										
Annotations	Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician			
Notes	7	29y	M	abdominal pain	Jack	15:26	04/12/01	langdon			
Clinical	12	63y	F	car drove off cliff	Grace	11:26	04/12/01	17 MVA	langdon		
Clinical History		18m	M	bean in nose	Ricky	15:44	04/12/01	28 Nose	langdon		
Exam											
Course											
Dx/DI											
Viewing											
Report											
Discharge											
Prescription											
Excuse											
Printing											
Clinical											
Discharge											
Closure											

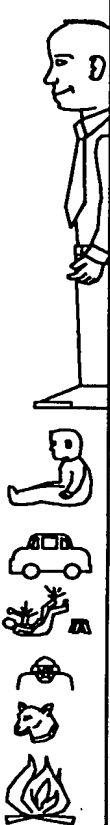
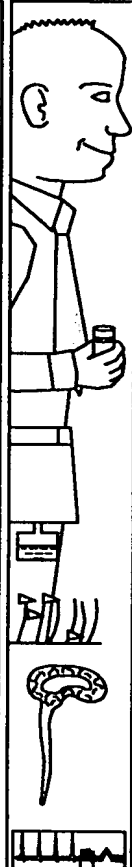
Patients Waiting										
Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician			
			NEW COMPLAINT	NEW PATIENT						
49y	F		horse stepped on foot	Ethyl	16:37	04/12/01				
118y	F		headache	Mary	16:26	04/12/01				
56y	M		car crash	Ernie	16:18	04/12/01				
37y	M		chest pain	Desi	15:04	04/12/01				

5/36

FIG. 6

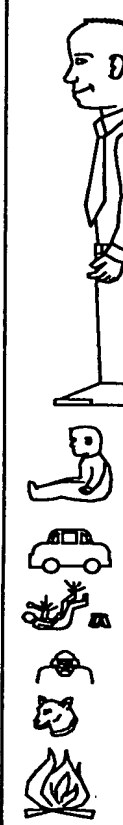
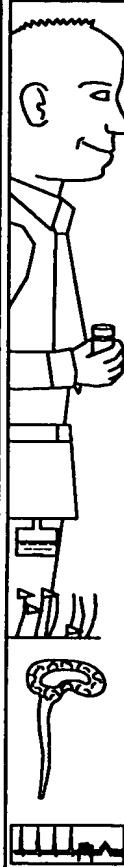
T-Chart	User rlangdon									
Jack	File Edit View Setup									
My Home	My Patients									
Annotations	Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
Notes	7	63y	F	car drove off cliff	Grace	11:26	04/12/01	17 MVA	langdon	
Clinical	8	29y	M	abdominal pain	Jack	15:26	04/12/01		langdon	
History	12	18m	M	bean in nose	Ricky	15:44	04/12/01	28 Nose	langdon	
Exam										
Course										
Dx/DI										
Viewing										
Report										
Discharge										
Prescription	Room	Age	Sex	Chief Complaint	Name	Time	Template	Physician		
Excuse				NEW COMPLAINT	NEW PATIENT					
Printing	49y	F	F	horse stepped on foot	Ethyl	16:37	04/12/01			
Clinical	118y	F	F	headache	Mary	16:26	04/12/01			
Discharge	56y	M	M	car crash	Ernie	16:18	04/12/01			
Closure	37y	M	M	chest pain	Desi	15:04	04/12/01			

FIG. 7

T-Chart Template Selector			
Trauma		Medicine	
	1 Head Injury	26 Headache	
	2 Eye Problems	27 Ear Complaints	
	3 head Injury, Facial	28 Nose	
	4 Neck/Back Pain or Injury	29 Throat or Dental Pain	
	5 Shoulder Injury	30 Cough	
	6 Upper Extremity Injury	31 Wheezing/Asthma	
	7 Trunk Injury	32 Dyspnea	
	8 Low Back Pain or Injury	33 Chest Pain	
	9 Hand/Wrist Injury	34 Palpitations	
	10 Hip Injury	35 Upper Extremity Pain	
	11 Lower Extremity Injury	36 Abdominal Pain	
	12 Ankle/Foot Injury	37 Vomiting/Diarrhea	
	13 Plantar Puncture Wound	38 GI bleeding/Rectal Pain	
	14 Pediatric Illness	39 Female GU	
	15 Asthma-pediatric	40 OB Problems	
	16 Pediatric trauma	41 Male GU	
	17 MVA	42 Lower Extremity Pain	
	17a MCA Bike/Pedestrian	43 Skin Rash/Abscess	
	18 Multiple trauma	44 Allergy	
	19 Fall	45 Changed Mental Status	
	20 Assault	46 Focal Neuro Deficit	
	21 Animal Bite	47 Dizzy	
	22 Major Burn/Smoke Inhalation	48 Syncope	
	23 Recheck/Suture Removal	49 Seizure	
24 General	50 CPR		
	51 Critical Care		
	52 Overdose		
	53 Psych		

Ok Cancel

FIG. 8

T-Chart Template Selector			
Trauma		Medicine	
	1 Head Injury	26 Headache	
	2 Eye Problems	27 Ear Complaints	
	3 head Injury, Facial	28 Nose	
	4 Neck/Back Pain or Injury	29 Throat or Dental Pain	
	5 Shoulder Injury	30 Cough	
	6 Upper Extremity Injury	31 Wheezing/Asthma	
	7 Trunk Injury	32 Dyspnea	
	8 Low Back Pain or Injury	33 Chest Pain	
	9 Hand/Wrist Injury	34 Palpitations	
	10 Hip Injury	35 Upper Extremity Pain	
	11 Lower Extremity Injury	36 Abdominal Pain	
	12 Ankle/Foot Injury	37 Vomiting/Diarrhea	
	13 Plantar Puncture Wound	38 GI bleeding/Rectal Pain	
	14 Pediatric Illness	39 Female GU	
	15 Asthma-pediatric	40 OB Problems	
	16 Pediatric trauma	41 Male GU	
	17 MVA	42 Lower Extremity Pain	
	17a MCA Bike/Pedestrian	43 Skin Rash/Abscess	
	18 Multiple trauma	44 Allergy	
	19 Fall	45 Changed Mental Status	
	20 Assault	46 Focal Neuro Deficit	
	21 Animal Bite	47 Dizzy	
	22 Major Burn/Smoke Inhalation	48 Syncope	
	23 Recheck/Suture Removal	49 Seizure	
24 General	50 CPR		
	51 Critical Care		
	52 Overdose		
	53 Psych		

Ok Cancel

FIG. 9A

<div style="border: 1px solid black; padding: 2px;">T-Chart</div> <div style="border: 1px solid black; padding: 2px;">Jack</div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Home</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Annotations</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Notes</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Clinical</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>History</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Exam</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Course</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Dx/DI</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Viewing</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Report</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Discharge</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Prescription</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Excuse</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Printing</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Clinical</div> </div> </div> <div style="border: 1px solid black; padding: 2px;"> <div style="display: flex; align-items: center;"> <div style="width: 20px; height: 20px; border: 1px solid black; margin-right: 5px;"></div> <div>Discharge</div> </div> </div>	<div style="border: 1px solid black; padding: 5px;"> <div style="display: flex; justify-content: space-between;"> <div>Abdominal Pain</div> <div>time: _____ room: _____</div> </div> <div style="margin-top: 5px;"> arrived: pvt vehicle EMS context: _____ historian: patient EMS family limited by: _____ </div> <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">OHPI</div> <div style="margin-top: 5px;"> chief complaint: abdominal pain _____ flank pain _____ started: just PTA today last night yesterday _____ </div> <div style="margin-top: 5px;"> still present _____ gone _____ timing: _____ </div> <div style="margin-top: 5px;"> <div style="display: flex; justify-content: space-between;"> <div> quality _____ "pain" _____ sharp _____ stabbing _____ cramping _____ burning _____ dull _____ migrating _____ ... _____ </div> <div> location: R chest - central- L chest epig RUQ upper LUQ generalized o R flank L flank R back L back R pelvis suprapub LQ L pelvis </div> </div> </div> </div>	<div style="border: 1px solid black; padding: 5px;"> <div style="display: flex; justify-content: space-between;"> <div>OPROS</div> <div>CONSTITUTIONAL</div> </div> <div style="margin-top: 5px;"> GI _vomiting blood _____ _black stools _____ _bloody stools _____ URINARY _difficulty w/urination _____ _pain w/urination _____ _frequency _____ Female _____pregnant _____ LNMP _____ _missed periods _____irreg _____ _abdominal bleeding _____ _all systems neg. except as marked _____ </div> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <div style="display: flex; justify-content: space-between;"> <div>OPAST Hx</div> <div></div> </div> <div style="margin-top: 5px;"> _negative _____see nurses notes _____ _peptic ulcer _____ _gall stones _____ _bowel obstruction _____ _kidney stones _____ _heart diz _____neuro diz _____ _lung diz _____GI diz _____ _renal dz _____other dz _____ _HTN _____diabetes _____ _hyperlipidemia _____ _previous surgery _____ _abdominal surgery _____ </div> </div>
---	---	--

9/36

FIG. 9B

<div style="border: 1px solid black; padding: 5px;"> <div style="display: flex; justify-content: space-between;"> <div> <p>Closure</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p> </div> <div> <p>similar symptoms previously: once twice sev. times many times - occasionally frequently milder as bad worse varying</p> <p>0</p> </div> </div> <div style="border-top: 1px solid black; padding-top: 5px;"> <p>recently seen _____ ED office clinic hospitalized</p> <p>0</p> </div> </div>		<div style="border: 1px solid black; padding: 5px;"> <p>0 MEDS _none _see nurses notes</p> <hr/> <p>0 ALLERGIES _NKDA _see nurses notes</p> <hr/> <p>0 SOCIAL Hx smoker _____ ETOH _____ drugs _____</p> <p>residence/travel: _____</p> <hr/> <p>0 FAMILY Hx gall bladder _____ heart dz _____ hx of: _____</p> <hr/> </div>	
--	--	--	--

FIG. 10

<div style="border: 1px solid black; padding: 5px;"> <p>Abdominal Pain time: _____ room: _____</p> <p>arrived: pvt vehicle EMS _____ context: _____</p> <p>historian: patient EMS family _____ limited by: _____</p> <p>OHPI</p> <p>chief complaint: abdominal pain _____ flank pain _____</p> <p>started: just PTA today last night yesterday _____</p> <p>still present _____ gone _____ timing: _____</p> <p>quality "pain" sharp location: R chest -central-L chest / epig</p> </div>		<div style="border: 1px solid black; padding: 5px;"> <p>GI</p> <p>CONSTITUTIONAL</p> <p>_vomiting blood _____</p> <p>_black stools _____</p> <p>_bloody stools _____</p> <p>URINARY</p> <p>_difficulty w/urination _____</p> <p>_pain w/urination _____</p> <p>_frequency _____</p> <p>Female _pregnant _____</p> <p>LNMP _____</p> <p>fever _chills _____</p> <p>Neuro & EENT</p> <p>_headache _____</p> <p>_sore throat _____</p> <p>_blurred vision _____</p> <p>CVS & Pulmonary</p> <p>_chest pain _____</p> <p>_difficulty breathing _____</p> <p>_cough _____</p> </div>	
---	--	--	--

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle	EMS	context: _____	
historian: patient		EMS family	limited by: _____		
OHPI					
chief complaint: abdominal pain		flank pain _____			
started: just PTA today		last night yesterday _____			
still present _____		gone _____		timing: _____	
quality		location: R chest - central- L chest			
"pain"		epig			
sharp		RUQ upper LUQ			
stabbing		generalized			
cramping		L flank			
burning		L flank			
dull		L flank			
migrating		L flank			
...		L flank			
well localized		L flank			
diffuse		L flank			
radiating to: _____		additional pain _____			
associated symptoms:		_____			
nausea _____		vomiting _____			
loss of appetite _____		diarrhea _____			
severity of pain: _____		_____			
modifying factors: _____		_____			

FIG. 12

T-Chart	Abdominal Pain time: _____ room: _____	
Jack	arrived: pvt vehicle EMS _____ context: _____	
<input checked="" type="checkbox"/> Home	historian: patient EMS family _____ limited by: _____	
Annotations	<div style="border: 1px solid black; padding: 2px;">OHPI</div>	
<input checked="" type="checkbox"/> S	chief complaint: <u>abdominal pain</u> _____ flank pain _____ started: just PTA today last night yesterday _____	
<input checked="" type="checkbox"/> Notes	still present _____ gone _____ timing: _____	
<input checked="" type="checkbox"/> Clinical	quality: _____ location: _____ "pain" _____ sharp _____ stabbing _____ cramping _____ burning _____ dull _____ migrating _____ ... _____ well localized _____ diffuse _____	
<input checked="" type="checkbox"/> History	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> R chest - central - L chest epig RUQ upper LUQ generalized R flank L flank </div> <div style="text-align: center;"> LLQ L back </div> </div>	
<input checked="" type="checkbox"/> Exam	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> RLQ R pelvis suprapub </div> <div style="text-align: center;"> LQ L back </div> </div>	
<input checked="" type="checkbox"/> Course	radiating to: _____ additional pain _____ associated symptoms: _____	
<input checked="" type="checkbox"/> Dx/DI	nausea _____ vomiting _____ loss of appetite _____ diarrhea _____ severity of pain: _____ modifying factors: _____	
<input checked="" type="checkbox"/> Viewing		
<input checked="" type="checkbox"/> Report		
<input checked="" type="checkbox"/> Discharge		
<input checked="" type="checkbox"/> Prescription		
<input checked="" type="checkbox"/> Excuse		
<input checked="" type="checkbox"/> Printing		
<input checked="" type="checkbox"/> Clinical		
<input checked="" type="checkbox"/> Discharge		

[illegible]

FIG. 14

T-Chart	Abdominal Pain time: _____ room: _____	
Jack	arrived: prt vehicle EMS _____ context: _____	
<input checked="" type="checkbox"/> Home	historian: patient EMS family _____ limited by: _____	
Annotations	OHP	
<input checked="" type="checkbox"/> S	chief complaint: <u>Abdominal pain</u> _____ flank pain _____	
<input checked="" type="checkbox"/> Notes	started: just PTA today last night yesterday _____	
Clinical	still present _____ gone _____ timing: _____	
History	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>quality: "pain" _____</p> <p>sharp _____</p> <p>stabbing _____</p> <p>cramping _____</p> <p>burning _____</p> <p>dull _____</p> <p>migrating _____</p> <p>... well localized _____</p> <p>diffuse _____</p> </div> <div style="width: 50%;"> <p>location: R chest -central- L chest</p> <p>epig _____</p> <p>RUQ upper LUQ _____</p> <p>generalized _____</p> <p>R flank _____</p> <p>L flank _____</p> <p>RLQ _____</p> <p>LLQ _____</p> <p>R pelvis pelvis L pelvis _____</p> <p>suprapub _____</p> <p>R back _____</p> <p>L back _____</p> </div> </div>	
Exam	radiating to: _____ additional pain _____	
Course	associated symptoms: _____	
Dx/DI	nausea _____ vomiting _____	
Viewing	loss of appetite _____ diarrhea _____	
Report	severity of pain: _____	
Discharge	modifying factors: _____	
Prescription		
Excuse		
Printing		
Clinical		
Discharge		

OROS		
GI	<u>vomiting blood</u> _____ <u>black stools</u> _____ <u>bloody stools</u> _____ URINARY _____ <u>difficulty w/urination</u> _____ <u>pain w/urination</u> _____ <u>frequency</u> _____ <u>Female</u> _____ <u>LNMP</u> _____ <u>missed periods</u> _____ <u>abdominal bleeding</u> _____ <u>all systems neg. except as marked</u> _____	
	CONSTITUTIONAL <u>fever</u> _____ <u>chills</u> _____ <u>Neuro & EENT</u> _____ <u>headache</u> _____ <u>sore throat</u> _____ <u>blurred vision</u> _____ <u>CYS & Pulmonary</u> _____ <u>chest pain</u> _____ <u>difficulty breathing</u> _____ <u>cough</u> _____ <u>MS & Skin</u> _____ <u>joint pain</u> _____ <u>back pain</u> _____ <u>skin rash</u> _____	
OPAST Hx	<u>negative</u> _____ <u>see nurses notes</u> _____ <u>peptic ulcer</u> _____ <u>gall stones</u> _____ <u>bowel obstruction</u> _____ <u>kidney stones</u> _____ <u>heart diz</u> _____ <u>lung diz</u> _____ <u>renal dz</u> _____ <u>HTN</u> _____ <u>hyperlipidemia</u> _____ <u>previous surgery</u> _____ <u>abdominal surgery</u> _____	

14/36

FIG. 15

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		context: _____	
OH Home		historian: patient EMS family		limited by: _____	
Annotations		chief complaint: (abdominal pain)		flank pain	
L S		started: just PTA today last night yesterday			
Notes		still present _____		gone _____	timing: _____
Clinical		quality "pain"		location: R chest - central - L chest	
H History		sharp		epig RUQ upper LUQ	
Exam		stabbing		generalized	
Course		cramping		R flank	
Dx/DI		burning		L flank	
Viewing		dull		RUQ LLQ	
Report		migrating		R pelvis pelvis L pelvis	
Discharge		... well localized		suprapub	
Prescription		diffuse		R back	
Excuse		radiating to: _____		additional pain _____	
Printing		associated symptoms:		nausea _____ vomiting _____	
Clinical		loss of appetite _____		diarrhea _____	
Discharge		severity of pain: _____		modifying factors: _____	

OPROS		OPAST Hx	
GI	vomiting blood _____ black stools _____ bloody stools _____ URINARY difficulty w/urination _____ pain w/urination _____ frequency _____ Female pregnant _____ LNMP missed periods irreg _____ abdominal bleeding _____ all systems neg. except as marked	CONSTITUTIONAL fever chills _____ Neuro & EENT headache _____ sore throat _____ blurred vision _____ CVS & Pulmonary chest pain _____ difficulty breathing _____ cough _____ MS & Skin joint pain back pain _____ skin rash _____	negative see nurses notes _____ peptic ulcer _____ gall stones _____ bowel obstruction _____ kidney stones _____ heart diz _____ lung diz _____ renal dz _____ HTN _____ hyperlipidemia _____ previous surgery _____ abdominal surgery _____

FIG. 16

T-Chart															
Jack															
Home															
Annotations															
L S															
Notes															
Clinical															
History															
Exam															
Course															
DxDI															
Viewing															
Report															
Discharge															
Prescription															
Excuse															
Printing															
Clinical															
Discharge															
Closure															
Lock															

Clinical Report

Hospital Name-
Emergency Department
Street Address - 214-555-1212
12-Apr-2001

Patient Name: Jack

HISTORY OF PRESENT ILLNESS
Chief complaint- ABDOMINAL PAIN. He has had nausea and loss of appetite. No vomiting or diarrhea.

Physician Signature

FIG. 17

T-Chart	Abdominal Pain time: _____ room: _____	
Jack	arrived: pvt vehicle EMS	context: _____
OH Home	historian: patient EMS family	limited by: _____
Annotations	OHPI	
⌋ ⌋	chief complaint: <u>Abdominal pain</u> flank pain _____	
⌋ Notes	started: just PTA today last night yesterday _____	
Clinical	still present _____ gone _____ timing: _____	
⌋ History	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p>quality: "pain" _____</p> <p>sharp _____</p> <p>stabbing _____</p> <p>cramping _____</p> <p>burning _____</p> <p>dull _____</p> <p>migrating _____</p> <p>... _____</p> <p>well localized _____</p> <p>diffuse _____</p> </div> <div style="width: 50%;"> <p>location: R chest -central- L chest</p> <p style="margin-left: 40px;">epig</p> <p style="margin-left: 40px;">RUQ upper LUQ</p> <p style="margin-left: 40px;">generalized</p> <p style="margin-left: 40px;">o</p> <p style="margin-left: 40px;">R flank</p> <p style="margin-left: 40px;">L flank</p> <p style="margin-left: 40px;">R back</p> <p style="margin-left: 40px;">L back</p> <p style="margin-left: 40px;">R pelvis</p> <p style="margin-left: 40px;">suprapub</p> <p style="margin-left: 40px;">^</p> <p style="margin-left: 40px;">additional pain _____</p> </div> </div>	
Exam	radiating to: _____ associated symptoms: _____	
Course	nausea _____ vomiting _____	
Dx/DI	loss of appetite _____ diarrhea _____	
Viewing	severity of pain: _____	
Report	modifying factors: _____	
Discharge		
Prescription		
Excuse		
Printing		
Clinical		
Discharge		

OROS	GI vomiting blood _____ black stools _____ bloody stools _____ URINARY difficulty w/urination _____ pain w/urination _____ frequency _____ Female _____ pregnant _____ LNMP _____ missed periods irreg _____ abdominal bleeding _____ all systems neg. except as marked _____	CONSTITUTIONAL fever _____ chills _____ Neuro & EENT headache _____ sore throat _____ blurred vision _____ CVS & Pulmonary chest pain _____ difficulty breathing _____ cough _____ MS & Skin joint pain _____ back pain _____ skin rash _____
OPAST Hx	negative _____ see nurses notes _____ peptic ulcer _____ gall stones _____ bowel obstruction _____ kidney stones _____	heart diz _____ neuro diz _____ lung diz _____ GI diz _____ renal dz _____ other dz _____ HTN _____ diabetes _____ hyperlipidemia _____ previous surgery _____ abdominal surgery _____

FIG. 18

T-Chart	Abdominal Pain time: _____ room: _____		
Jack	arrived: pvt vehicle EMS	EMS context:	
Home	historian: patient EMS family	limited by:	
Annotations	OHPI		
Ⓛ	chief complaint: (abdominal pain) flank pain		
Notes	started: just PTA today last night yesterday		
Clinical	still present _____ gone _____ timing: _____		
History	<div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> location: R chest - central - L chest epig RUQ upper LUQ generalized R flank RUQ LLQ R pelvis pelvis L pelvis suprapub R back L flank L back </div> <div style="width: 45%;"> quality "pain" sharp stabbing cramping burning dull migrating ... well localized diffuse </div> </div>		
Exam	radiating to: _____ additional pain _____		
Course	associated symptoms:		
Dx/DI	nausea _____ vomiting _____		
Viewing	loss of appetite _____ diarrhea _____		
Report	severity of pain: _____		
Discharge	modifying factors: _____		
Prescription			
Excuse			
Printing			
Clinical			
Discharge			

FIG. 19

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		context: _____	
(97) Home		historian: patient EMS family		limited by: _____	
Annotations		OHPI			
/ S		chief complaint: (abdominal pain)		flank pain _____	
Notes		started: just PTA today last night yesterday			
Clinical		still present _____		gone _____	timing: _____
History		location: R chest - central - L chest			
Exam		epig RUQ upper LUQ			
Course		generalized			
Dx/DI		R flank			
Viewing		LLQ			
Report		RLQ			
Discharge		R pelvis pelvis L pelvis			
Prescription		suprapub			
Excuse		R back			
Printing		additional pain _____			
Clinical		radiating to: _____			
Discharge		associated symptoms: _____			
		nausea _____			
		loss of appetite _____			
		severity of pain: _____			
		modifying factors: _____			

OPAST Hx		negative _see nur		negative _see nur	
		peptic ulcer		peptic ulcer	
		gall stones		gall stones	
		bowel obstruction		bowel obstruction	
		kidney stones		kidney stones	

GI		vomiting blood		CONSTITUTIONAL	
		black stools		fever _chills	
		bloody stools		Neuro & EENT	
URINARY		difficulty w/urination		headache	
		pain w/urination		sore throat	
		frequency		blurred vision	
		Female _pregnant		CVS & Pulmonary	
LNMP		missed periods		chest pain	
		abdominal bleed		difficulty breathing	
		all systems neg. e		cough	

minutes		(<<)	
hours		ago	
days		times	
weeks			
months			
years			
today		since yesterday	
-gone now		-still present	
-improving		-worsening	

COUGH	
mild moderate (severe)	
dry / (productive)	
scant moderate copious (thick) thin	
clear yellow (green) brown white	
(blood tinged) frank blood	
cough changed from baseline smoker	
sputum changed from baseline	
similar to previous symptoms	

TSYS 25,410

Title: METHOD FOR ENTERING,
RECORDING, DISTRIBUTING AND
REPORTING DATA

Inventor(s): Woodrow W. Gandy et al
U.S. Serial # 09/927,972

18/36

FIG. 20

T-Chart	Jack	Home	Annotations	Notes	Clinical	History	Exam	Course	Dx/DI	Viewing	Report	Discharge	Prescription	Excuse	Printing	Clinical	Discharge	Closure	
---------	------	------	-------------	-------	----------	---------	------	--------	-------	---------	--------	-----------	--------------	--------	----------	----------	-----------	---------	--

Clinical Report

Hospital Name-
Emergency Department
Street Address - 214-555-1212
12-Apr-2001

Patient Name: Jack

HISTORY OF PRESENT ILLNESS

Chief complaint- ABDOMINAL PAIN. He has had nausea and loss of appetite. No vomiting or diarrhea.

REVIEW OF SYSTEMS

The patient has had a sever cough productive of thick, green, blood tinged sputum. No frankly bloody sputum.

Physician Signature

20/36

FIG. 21

T-Chart		Abdominal Pain		time: _____	room: _____
Jack		arrived: pvt vehicle EMS		context: _____	
OHPI		historian: patient EMS family		limited by: _____	
Annotations		chief complaint: (abdominal pain)		flank pain _____	
L S		started: just PTA today last night yesterday			
Notes		still present _____ gone _____		timing: _____	
Clinical		quality "pain" _____		location: R chest, central-L chest	
Hx History		sharp _____		epig _____	
Exam		stabbing _____		RUQ upper LUQ _____	
Course		cramping _____		generalized _____	
Dx/DI		burning _____		R flank _____	
Viewing		dull _____		LLQ _____	
Report		migrating _____		R pelvis pelvis L pelvis _____	
Discharge		... well localized _____		suprapub _____	
Prescription		diffuse _____		R back _____	
Excuse		radiating to: _____		additional pain _____	
Printing		associated symptoms: _____		nausea _____	
Clinical		loss of appetite _____		vomiting _____	
Discharge		severity of pain: _____		diarrhea _____	
		modifying factors: _____			

OROS		GI		CONSTITUTIONAL	
_vomiting blood _____		_black stools _____		_fever _____	
_bloody stools _____		_URINARY		_Neuro & EENT	
_difficulty w/urination _____		_pain w/urination _____		_headache _____	
_frequency _____		_Female _____		_sore throat _____	
_pregnant _____		_chest pain _____		_blurred vision _____	
_missed periods _____		_abdominal bleed _____		_CVS & Pulmonary	
_all systems neg. e _____		_chest pain _____		_difficulty breathing _____	
		_cough _____			
OPAST Hx		negative _____		_see nur _____	
_peptic ulcer _____		_gall stones _____		_bowel obstruction _____	
_kidney stones _____					

minutes (<<)		1 2 3 4 5 -		ago	
hours		for 6 7 8 9 0 1/2		times	
days		several		many	
weeks		occasionally		today	
months		since yesterday		recently	
years		-gone now		-still present	
				-improving	
				-worsening	

COUGH		mild moderate (severe)	
dry / (productive)		scant moderate copious (thick) thin	
clear yellow (green) brown white		(blood tinged) frank blood	
cough changed from baseline		sputum changed from baseline	
smoker		similar to previous symptoms	

FIG. 22

T-Chart	Abdominal Pain time: _____ room: _____	
Jack	arrived: pvt vehicle EMS _____ context: _____	
<input checked="" type="checkbox"/> Home	historian: patient EMS family _____ limited by: _____	
Annotations	<div style="border: 1px solid black; padding: 2px;"> OHP1 chief complaint: <u>abdominal pain</u> _____ flank pain _____ started: just PTA today last night yesterday _____ </div>	
<input checked="" type="checkbox"/> Notes	still present _____ gone _____ timing: _____ quality "pain" _____ location: _____ sharp _____ RUQ upper LUQ _____ L flank stabbing _____ epig _____ cramping _____ generalized _____ burning _____ RUQ LLQ _____ dull _____ R flank _____ L back migrating _____ R back _____ ... _____	
<input checked="" type="checkbox"/> Clinical	well localized _____ diffuse _____	
<input checked="" type="checkbox"/> History	radiating to: _____ additional pain _____ associated symptoms: _____	
<input checked="" type="checkbox"/> Exam	nausea _____ vomiting _____ loss of appetite _____ diarrhea _____ severity of pain: _____ modifying factors: _____	
<input checked="" type="checkbox"/> Course		
<input checked="" type="checkbox"/> Dx/DI		
<input checked="" type="checkbox"/> Viewing		
<input checked="" type="checkbox"/> Report		
<input checked="" type="checkbox"/> Discharge		
<input checked="" type="checkbox"/> Prescription		
<input checked="" type="checkbox"/> Excuse		
<input checked="" type="checkbox"/> Printing		
<input checked="" type="checkbox"/> Clinical		
<input checked="" type="checkbox"/> Discharge		

OROS	GI vomiting blood _____ black stools _____ bloody stools _____ URINARY difficulty w/urination _____ pain w/urination _____ frequency _____ Female _____ pregnant _____ LNMP missed periods _____ irreg _____ abdominal bleeding _____ all systems neg. except as marked _____	
OPAST Hx	negative _____ see nurses notes _____ peptic ulcer _____ gall stones _____ bowel obstruction _____ kidney stones _____ heart diz _____ neuro diz _____ lung diz _____ GI diz _____ renal dz _____ other dz _____ HTN _____ diabetes _____ hyperlipidemia _____ previous surgery _____ abdominal surgery _____	

OROS	CONSTITUTIONAL fever _____ chills _____ Neuro & EENT _____ headache _____ sore throat _____ blurred vision _____ CVS & Pulmonary _____ chest pain _____ difficulty breathing _____ cough _____ severe, productive, thick gr _____ MS & Skin _____ joint pain _____ back pain _____ skin rash _____	
-------------	---	--

FIG. 23

T-Chart	MVA	time: _____	room: _____
Jim	arrived: pvt vehicle EMS _____	context: _____	
Home	historian: patient EMS family _____	limited by: _____	
Annotations	OHPI		
Annotations	chief complaint: MVA _____		
Annotations	location of injuries: _____		
Annotations	occurred: just PTA today last night yesterday _____		
Annotations	pain: none _____ mild _____ moderate _____ severe _____		
Annotations	assoc: blow head _____ neck pain _____ LOC _____ dazed _____ seizure _____		
Annotations	mechanism details: 0 _____		
Annotations	OROS		
Annotations	numbness weakness _____ trouble breathing _____		
Annotations	hearing loss _____ nausea vomiting _____		
Annotations	loss of vision _____ bladder dysfunction _____		
Annotations	headache _____ skin laceration _____		
Annotations	chest pain _____ fever recently ill _____		
Annotations	depressed _____ all systems neg. except as marked _____		
Annotations	OPAST HISTORY		
Annotations	neg see nurses notes heart dz neuro dz _____		
Annotations	tetanus: UTD >5 >10 unk _____ lung dz GI dz _____		
Annotations	renal dz other dz _____		
Annotations	HTN diabetes _____		
Annotations	previous surgery _____		
Annotations	0 MEDS none see nurses notes _____		
Annotations	0 ALLERGIES NKDA see nurses notes _____		
Annotations	0 SOCIAL HX smoker _____ ETOH _____ drugs _____		
Annotations	residence/travel: _____		
Annotations	PHYSICAL EXAM		
Annotations	bckbrd c-collar _____ nurses notes rev'd _____ VS rev'd _____		
Annotations	PHYSICAL EXAM		
Annotations	_alert _____		
Annotations	_NAD _____		
Annotations	_anxious / lethargic / obtunded _____		
Annotations	_in distress mild mod severe _____		
Annotations	HEAD		
Annotations	_Battle's sign _____ raccoon eyes _____		
Annotations	_non-tender _____		
Annotations	_no swelling _____		
Annotations	<div style="display: flex; justify-content: space-around; align-items: center;"> <div style="text-align: center;"> </div> <div style="text-align: center;"> <p>Add'l Injury 0</p> </div> </div>		
Annotations	NECK		
Annotations	_verteb. tenderness _____ painful movement _____		
Annotations	_non-tender _____		
Annotations	_painless ROM _____		
Annotations	EYES		
Annotations	_pupillary exam: _____		
Annotations	_ocular injury _____		
Annotations	_abnml fundoscopic _____		
Annotations	ENT		
Annotations	_hematympanum _____		
Annotations	_malocclusion _____		
Annotations	_no dental injury _____		
Annotations	_pharynx nml _____		

FIG. 24

T-Chart		RESPIRATORY		resp distress		0 NEURO		altered mental status		GCS	
Jim		_chest nontender		_chest wall injury #1		oriented x3		_CN deficit			
Home		_breath snds nml		_decreased breath sounds		_no motor deficit		_weakness		sensory deficit	
Annotations				_rales rhonchi		_no sensory deficit		_reflex exam:			
S				_wheezes crepitus		_reflexes nml					
Notes		CVS		_abnml rate techycardia bradycardia		SKIN		_cyanosis		pallor	
Clinical		_heart snds nml		_abnml rhythm		_intact		_cool skin		diaphoresis	
History		_pulses nml		_JVD present		_warm, dry		_skin rash		poor skin turgor	
Exam				_extra sounds		_nml color					
Course		ABDOMEN		_pulse exam		EXTREMITIES		_soft tissue tenderness			
Dx/Di		_soft		_obese		_atraumatic		_bony tenderness			
Viewing		_nontender		_tenderness #1		_nml inspection		_abrasions #1		#2	
Report		_no organomegaly		_guarding		_pelvis stable		_limping gait		cannot bear weight	
Discharge				_rebound		_no pedal edema		_gait not tested due to pain			
Prescription				_organomegaly							
Excuse				_abnml bowel sounds							
Printing				_distention							
Clinical		GU		_mass							
Discharge		_nml genitalia		_panneal hematoma							
		_nml vaginal exam		_blood at urethral meatus							
		RECTAL		_blood in stool							
		_nml rectal exam		_abnormal digital rectal							
		_heme neg stool									
		BACK		_tenderness #2							
		_nontender		_vertebral point tenderness							
		_ROM nml		_muscle spasm		limited ROM					
Closure											
ID											

RT

LT

24/36

FIG. 25

X-RAYS		PROCEDURE NOTES	
_nml / NAD except as noted _____ _independently visualized by me _discussed with radiologist _____ _interpreted by me contemporaneously _interpreted by radiologist _____		0 <u>Intubation</u> 0 <u>Splint</u> 0 <u>Ventilator Management</u> 0 <u>Wound Repair</u> 0 <u>Central Line</u> 0 <u>Chest Tube</u>	
<div style="display: flex; align-items: center;"> <div style="margin-right: 20px;"> R skull - + facial - + nasal - + orbits - + mandible - + c-spine - + </div> <div style="text-align: center;"> </div> <div style="margin-left: 20px;"> L clavicle - + scapula - + shoulder - + humerus - + elbow - + forearm - + wrist - + hand - + digit - + hip - + femur - + knee - + patella - + tib/fib - + ankle - + foot - + toe(s) - + </div> </div>		PROGRESS TIME _____ -now- stable unstable sx's much better better unchg'd exam improved unchanged [APPLY]	
EKG / LABS / SPECIAL STUDIES 0 EKG _nml 0 CT Head _NAD 0 CT Abdomen _NAD 0 Labs _nml 0 CT Chest _NAD 0 Other studies _neg		0 <u>trauma course</u> 0 <u>Resp / CVS</u> 0 <u>CPR</u> 0 <u>re-evaluation</u> consultation / review of records D/W Dr. _____ old records ordered _____ D/W Dr. (#2) _____ old records reviewed _____ _tried - can't contact Dr. _____ records req - unavailable _____ _family consultation _____ further history sought _____ hospital admission or transfer _admitted _____ good condition _____ _transferred _____ stable _____ _observation status _____	

FIG. 26

T-Chart		CLINICAL IMPRESSION		PRESCRIPTIONS	
Jim _____ Home _____ Annotations _____ Notes _____ Clinical _____ History _____ Exam _____ Course _____ Dx/Di _____ Viewing _____ Report _____ Discharge _____ Prescription _____ Excuse _____ Printing _____ Clinical _____ Discharge _____ Closure _____ _____		acute pain _____ MVA _____ MCA _____ bike _____ pedestrian _____ skin _____ fracture _____ laceration _____ skull _____ rib _____ abrasion(s) _____ facial _____ pelvic _____ skin avulsion _____ spine _____ hip _____ foreign body, soft tissue _____ upper ext _____ lower ext _____ soft tissue _____ wrist _____ ankle _____ cervical strain _____ hand _____ foot _____ neck pain _____ other / major injury _____ back pain _____ concussion _____ strain _____ head injury _____ sprain _____ spinal injury _____ contusion _____ hemorrhage _____ _____ hypotension _____ _____ shock _____ dislocation _____ respiratory failure _____ shoulder _____ finger _____ elbow _____ toe _____ knee injury _____ knee injury _____ hemarthrosis _____ knee instability _____ abnormal test _____ general _____ lifestyle issues _____ hypertension _____ _____ diabetes _____ more diagnoses _____ Allergy _____ 0 Infectious Disease _____ 0 Ortho/Surg _____ Cardiology _____ 0 Int Medicine, Gen I _____ 0 Pediatrics _____ Dermatology _____ 0 Mouth/Dental _____ 0 Psychiatric _____ ENT 0 Eye _____ 0 Pulmonary _____ 0 Toxicology _____ Environmental _____ 0 Neurology _____ 0 Trauma _____ Gastrointestinal _____ 0 OB-GYN _____ 0 Urology _____		OTC meds _____ Acetaminophen _____ Motrin _____ pain / nausea _____ Darvocet-N _____ Lortab _____ Phenergan _____ Tylenol w/Cod. _____ NSAID's _____ Ibuprofen _____ Lodine _____ Naproxen _____ muscle _____ Flexeril _____ Robaxin _____ Skelaxin _____ Soma _____ antibiotics _____ Augmentin _____ Cephalixin _____ Cipro 10d _____ Duricer _____ Erythromycin _____ Levaquin _____ Silvadene _____ more prescriptions _____ 0 Allergy/Decong _____ 0 Eye _____ 0 Nsaids _____ 0 Sedative _____ 0 Analgesics _____ 0 ENT _____ 0 M.Relax _____ 0 Skin _____ 0 Antibiotics _____ 0 GI _____ 0 Ob-Gyn _____ 0 Steroids _____ 0 Cardiac _____ 0 Neuro _____ 0 Pulmonary _____ 0 Urology _____ o DISCHARGE INSTRUCTIONS treatment _____ 0 activity / work-school _____ _c-collar _____ no restrictions _____ _ice _____ no strenuous activity _____ _wound care _____ elevate _____ _sling _____ splint _____ _rib belt _____ _crutches _____ _knee immobilizer _____ _elastic wrap _____ diet _____ no restrictions _____ clear liquids only _____ return if problems _____ follow-up _____ 0 w/ Dr. _____ w/ your doctor _____ 0 w/ Dr. (#2) _____ w/ specialist _____ return to ED _____ discharged home in _____	

T-Chart	Abdominal Pain	time: _____	room: _____
Mary	arrived: pvt vehicle EMS	context:	
	historian: patient EMS family	limited	
OHPI			
Annotations	chief complaint: abdominal pain _____ flank pa		
L S	started: just PTA today last night yesterday		
Notes	still present _____ gone _____ timing: _____		
Clinical	location: R chest - central-L chest		
History	sharp epig RUQ upper LUQ generalized L		
Exam	stabbing cramping burning dull migrating ... well localized diffuse		
Course	R flank R back RLQ LLQ R pelvis pelvis L pelvis suprapub ^ L		
Dx/DI	radiating to: _____ additional pain _____		
Viewing	associated symptoms: nausea vomiting loss of appetite diarrhea severity of pain: _____ modifying factors: _____		
Report			
Discharge			
Prescription			
Excuse			
Printing			
Clinical			
Discharge			

FIG. 28A

EVI	nurses notes rev'd	VS rev'd	0 2/other
Mary	PHYSICAL EXAM		
Home	_alert _NAD _anxious / lethargic / obtunded _in distress mild mod severe		
Annotations	EYES _conjunctival findings _scleral icterus _pale conjunctivae		
Notes	_abnl ear exam _runny nose _pharyngeal erythema _tonsillar exudate _dry mucous membranes		
Clinical	ENT _ears nml _nose nml _pharynx nml		
History	NECK _nml inspection _supple		
Exam	_JVD _cardiot bruit _lymphadenopathy _thyromegaly _meningeal signs		
Course	CVS _abnl rate tachycardia bradycardia _abnl rhythm _murmur _extra sounds _decrsd pulses		
Dx/DI	_nml rate/rhythm _heart sounds nml		
Viewing	RESPIRATORY _no resp distress _breath sounds nml _chest nontender		
Report	_resp distress _accessory muscles _decreased air movement _rales		
Discharge	_discharge		
Prescription	_prescription		
Excuse	_excuse		
Printing	_printing		
Clinical	_clinical		
Discharge	_discharge		

ABDOMEN	OBSE	scar	other
_soft	_tenderness #1	#2	
_nontender	_guarding		
_no organomegaly	_rebound		
	_organomegaly	_gravid uterus	
	_abnl bowel sounds		
	_distention		
	_mass		
0 FEM GENITALIA	_vag. bleeding	_discharge	
_external exam nml	_bimanual tenderness		
_bimanual exam nml	_enlarged uterus	_mass	
_speculum exam nml			
MALE GENITALIA	_tenderness		
_nml genitalia	_scrotal swelling		
_testes descended			
RECTAL	_blood in stool		
_nml rectal exam	_tenderness		
_nontender	_abnormal digital rectal		
_hemo neg stool			
BACK	_CVA tenderness		
_nml inspection			
EXTREMITIES	_pedal edema		
_nml ROM	_calf tenderness		
_no pedal edema			
SKIN	_cyanosis	_pallor	
_nml color	_cool skin	_diaphoresis	

B

FIG. 28B

<div>Closure</div> <div> <input type="checkbox"/> <input checked="" type="checkbox"/> </div>	_rhonchi _____ _wheezes _____ _prolonged expirations _____	(B)	_warm, dry _____ _no rash _____	_skin rash _____	_poor skin turgor _____
	0 NEURO _oriented x _____ _no motor deficit _____ _no sensory deficit _____ _reflexes nml _____	altered mental status _____ _CN deficit _____ _weakness _____ _sensory deficit _____ _reflex exam: _____			

FIG. 29

<p align="center">Clinical Report</p> <p align="center">Hospital Name - Emergency Department</p> <p align="center">Street Address - 214-555-1212</p> <p align="center">12-Apr-2001</p> <p align="center">Patient Name: Mary</p> <p>PHYSICAL EXAM</p> <p>Eyes: Scleral icterus. Pale conjunctivae.</p> <p>ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.</p> <p>Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.</p> <p>Abdomen: Obese. Rebound tenderness. Guarding present.</p> <p>Skin: Cyanosis. Skin rash.</p> <p>Neuro: Oriented X 3. No motor deficit. No sensory deficit.</p> <p align="right">_____ Physician Signature</p>

29/36

FIG. 30

EV1	nurses notes rev'd	VS rev'd	0 2/other	ABDOMEN	scar	other
Jane	PHYSICAL EXAM	gyn	obese	tenderness	#1	#2
Home	_alert _NAD EYES _nml inspection _PERRL ENT _ears nml _nose nml _pharynx nml NECK _nml inspection _supple CVS _nml rate/rhythm _heart sounds nml RESPIRATORY _no resp distress _breath sounds nml _chest nontender	_external exam nml _speculum exam nml _no vag discharge _no cervical lesions _os closed _bimanual exam nml _nontender bimanual _no pelvic mass RECTAL _nml rectal exam _heme neg stool _nontender	PELVIC EXAM (speculum) (bimanual) rectovag _herpes-like lesion(s) _vaginal discharge _vag. bleeding _IUD string visible _cervical erosion _cervicitis (cervical lesion) (cervical discharge) _cervical dilation _cervical os open _tissue in os in vagina _cervical effacement _cerv. motion tenderness _bimanual tenderness _pelvic mass _adnexal tenderness _adnexal mass / fullness _retroverted uterus _retroflexed uterus _uterine tenderness _enlarged uterus _decreased rectal tone _blood in stool _abnormal digital rectal	_egally _bowel sounds _n _ding _tenderness _uterus _ss _welling _stool _ss _digital rectal _erness _ema _erness _pallor _diaphoresis		

FIG. 31

T-Chart	<div style="text-align: center;"> <h2>Clinical Report</h2> <p>Hospital Name - Emergency Department Street Address - 214-555-1212 26-Jul-2001</p> <hr/> <p>Patient Name: Jane</p> </div>														
Jane															
Home															
Annotations															
L S															
Notes															
Clinical															
History															
Exam															
Course															
Dx1															
Viewing															
Report															
Discharge															
Prescription															
Excuse															
Printing															
Clinical															
Discharge															
Closure															
Signature															

PAST HISTORY
 Peptic ulcer, Gall stones, Bowel obstruction

PHYSICAL EXAM
 Eyes: Scleral icterus. Pale conjunctivae.
 ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.
 Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.
 Abdomen: Obese. Rebound tenderness. Guarding present.
 GU: Speculum and bimanual exam performed. Cervical lesion present.
 Discharge present from the cervical os.
 Skin: Cyanosis. Skin rash.
 Neuro: Oriented X 3. No motor deficit. No sensory deficit.

Physician Signature

31/36

FIG. 32

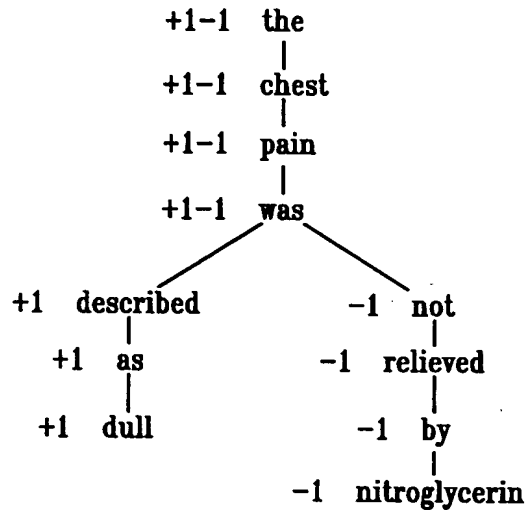
[illegible]

T-Chart		EKG / X-RAYS / STUDIES	PROCEDURE NOTES	
Jane	0 EKG _nml 0 CXR _NAD 0 V/Q scan _nml 0 Abdomen _NAD 0 IVP _NAD 0 Other X-rays _neg	0 CT Head _NAD 0 CT Chest _NAD 0 CT Abdomen _NAD 0 Abdominal Sono _NAD 0 Pelvic Sono _NAD 0 Other studies _neg	0 Intubation 0 Ventilator Management 0 Chest tube	0 Central Line 0 Thrombolytic Therapy
Annotations			PROGRESS	
			TIME: ____ - now stable unstable sx's gone much better better unchangedd exam improved unchanged	
Notes			[APPLY]	
Clinical	0 CBC nml except	0 Cardiac Enz nml except	Evaluation after reassessment. Physical exam findings are unchanged.	
History	WBC _____ Hgb _____ HCT _____ Plat _____ segs _____ bands _____ lymphs _____ monos _____	CK _____ CKMB _____ myoglobin _____ Troponin T _____ Troponin I _____ Pulse Ox _____ time _____ FI02 _____ O2 sat _____	Evaluation after multiple exams. Physical exam findings are unchanged. The patient's symptoms are unchanged.	
Dx/DI	Na _____ K _____ Cl _____ HC03 _____ Glu #2 _____ BUN _____ Cr _____ Tot Prol _____ Albumin _____ T.Bili _____ SGOT _____ Alk Phos _____ Ca _____ Mg _____ PO4 _____ Amylase _____ Lipase _____	Peak Flow _____ U/A _____ cath clean _____ nml except _____ WBCs _____ RBCs _____ bacteria _____ blood _____ leuk est _____ nitrite _____ gluc _____ ketones _____ Bili _____ protein _____ HCG _____ sHCG _____ Quant _____ uHCG _____	Evaluation after observation, results of tests back, analgesic and narcotic. Physical exam findings are improved. Symptoms much better.	
Viewing	0 COAG PT _____ PTT _____ INR _____	0 ABG time _____ FI02 _____ pO2 _____ pO2 sat _____ pCO2 _____ pH _____	0 general course 0 Resp / CVS 0 CPR 0 re-evaluation	
Report			consultation / review of records	
Discharge			_D/W Dr. _____ _old records ordered _____	
Prescription			_D/W Dr.(#2) _____ _old records reviewed _____	
Excuse			_tried - can't contact Dr. _____ _records req-unavailable _____	
Printing			_family consultation _____ _further history sought _____	
Clinical			hospital admission or transfer	
Discharge			_admit _____ _good condition _____	
Closure			_transfer _____ _stable _____	
			observation status _____	

FIG. 34

T-Chart	Clinical Report	
Jane	Hospital Name-	
Home	Emergency Department	
Annotations	Street Address - 214-555-1212	
✓ S	26-Jul-2001	
Notes	Patient Name: Jane	
Clinical	PAST HISTORY	
History	Peptic ulcer, Gall stones, Bowel obstruction	
Exam	PHYSICAL EXAM	
Course	Eyes: Scleral icterus. Pale conjunctivae.	
Dx/DI	ENT: Ears normal. Nasal discharge present. Dry mucous membranes present.	
Viewing	Neck: Meningeal signs present. Lymphadenopathy present. Thyromegaly.	
Report	Abdomen: Obese. Rebound tenderness. Guarding present.	
Discharge	GU: Speculum and bimanual exam performed. Cervical lesion present. Discharge present from the cervical os.	
Prescription	Skin: Cyanosis. Skin rash.	
Excuse	Neuro: Oriented X 3. No motor deficit. No sensory deficit.	
Printing	PROGRESS AND PROCEDURES	
Clinical	E.D. Course: Evaluation after reassessment. Physical exam findings unchanged.	
Discharge	Evaluation after multiple exams. Physical exam findings are unchanged. The patient's symptoms are unchanged.	
Closure	Evaluation after observation, results of tests back, analgesis and narcotic. Physical exam findings are improved. Symptoms much better.	
Signature	Physician Signature	

FIG. 35



the chest pain was described as dull
the chest pain was not relieved by nitroglycerin

FIG. 36

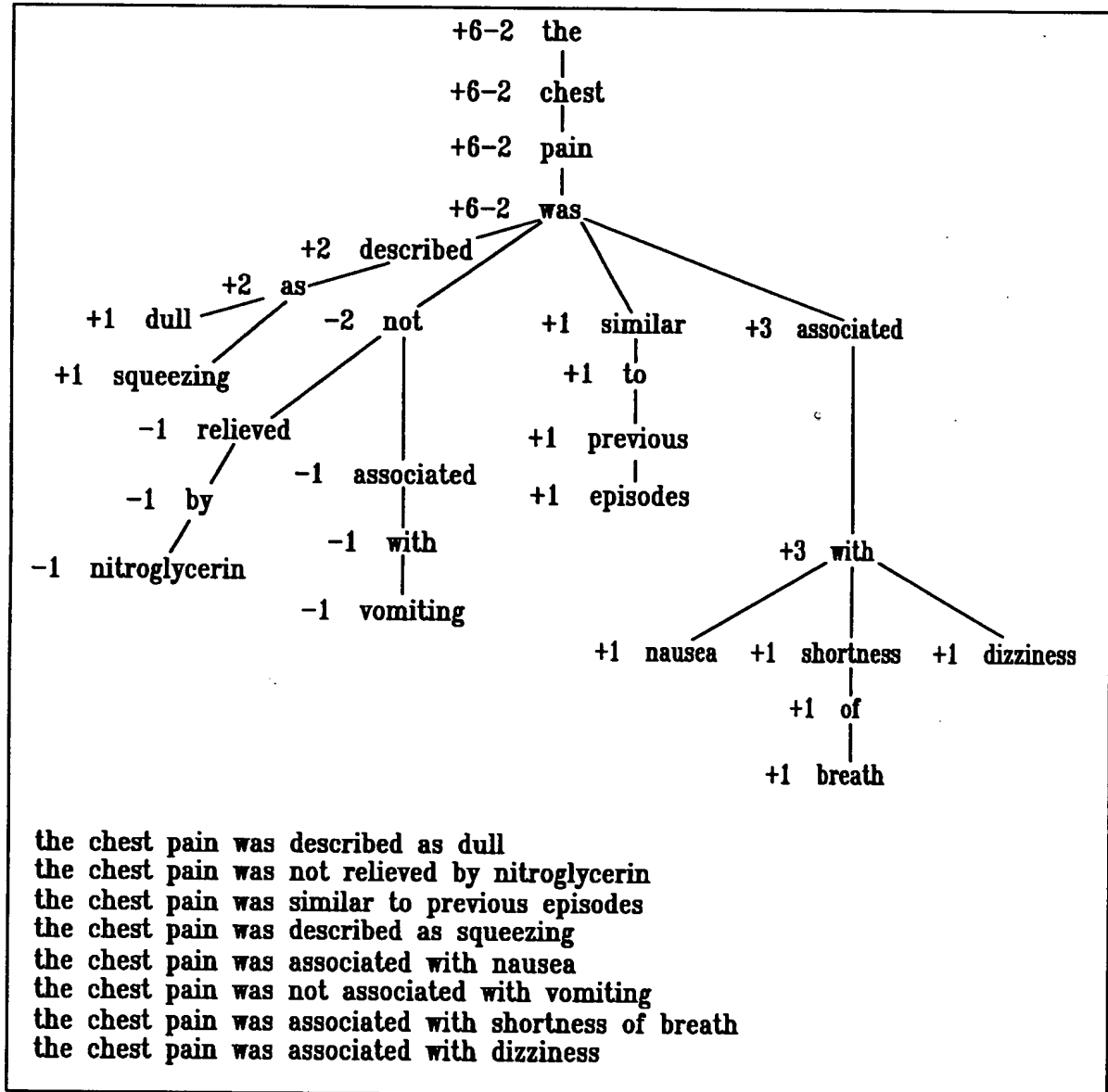


FIG. 37

Test TSysTPRL

the patient has had a prior history of ** cancer of the stomach

the patient has had a prior history of ** cancer of the brain

the patient has had a prior history of ** diabetes

the patient has had a prior history of ** congestive heart failure

the patient has had a prior history of ** gout

the patient has had a prior history of ** ingrown toenails

the patient has had a prior history of ** alcohol abuse

the patient has had a prior history of ** scabies

Generate

Min Text

Space

Semicolon

Comma

Crunch

The patient has had a prior history of cancer of the stomach, cancer of the brain, diabetes, congestive heart failure, gout, ingrown toenails, alcohol abuse and scabies.